MEDRX

3250 W. Pleasant Run, Suite 125 Lancaster, TX 75146-1069
Ph 972-825-7231 Fax 972-274-9022

Notice of Independent Review Decision

DATE OF REVIEW: 7/6/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
The item in dispute is the prospective medical necessity of Right C5-6 Selective Nerve Root Block.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
The reviewer is a Medical Doctor who is board certified in Physical Medicine and Rehabilitation.

REVIEW OUTCOME
Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

☐Upheld (Agree)
☒Overturned (Disagree)
☐Partially Overturned (Agree in part/Disagree in part)

The reviewer disagrees with the previous adverse determination regarding the prospective medical necessity of Right C5-6 Selective Nerve Root Block.

INFORMATION PROVIDED TO THE IRO FOR REVIEW
Records were received and reviewed from the following parties:

These records consist of the following (duplicate records are only listed from one source):
Records reviewed from.
Back Institute
- Follow up note- 5/30/12
- Consultation- 4/3/12
- Radiology Report- 4/3/12

Workers' Comp Services

Case Manager Letter- 2/15/12
M.D.
MRI cervical spine w/o contrast- 2/5/12
Health
CT Spine Thoracic w/o Contrast- 5/2/12
CT Spine Cervical w/o Contrast- 5/2/12
XR INJ Myelogram- 5/2/12
Medical Clinic
Occupational Medicine Follow-up visit- 6/5/12
Notification of Workers' Compensation Referral- 6/5/12
Medical Center
Progress Notes- 2/4/12
Demographics and Medication- 2/7/12
Lab Summary- 2/7/12
Radiology Chest - 2/4/12
Radiology Knee- 2/4/12
Radiology Pelvis- 2/4/12
Radiology Shoulder- 2/4/12
Radiology Humerus- 2/4/12
Radiology Hand- 2/4/12
Radiology Femur- 2/4/12
CT Head w/o Contrast- 2/4/12
CTA Neck CT Chest/Abd/Pelvis- 2/4/12
History and Assessment- 2/4/12
Texas Workers' Compensation
Work Status Report- 6/5/12
Records reviewed from back Institute
Back Institute
Script for Orders- 5/30/12
Medical Center
MRI Cervical Spine w/o Contrast-2/5/12
A copy of the ODG was not provided by the Carrier or URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

The injured worker sustained multiple injuries in an accident on xx/xx/xx while employed as a full-time. Injuries included T12 vertebral compression fracture, C5-C6 disc herniation and a comminuted, displaced closed fracture of the right femur. The worker was admitted to Medical Center and went to surgery on xx/xx/xx for retrograde intramedullary nail fixation of the right femur fracture and for removal of the traction pin. For a time there was numbness of the third finger of each hand. A thoracolumbar spinal orthosis was applied for comfort. The C5-C6 disc herniation was treated without surgery. The worker was transferred from intensive care on 02/06/2012. Physical therapy was continued with weight bearing as tolerated on the right lower extremity. A handwritten progress note on 02/07/2012 appears to mention a "C collar per NS". The worker was discharged on 02/07/2012.
Coventry Workers' Comp Services referred the injured worker to Dr. for care, evaluation and treatment of the spinal injuries, which were specifically listed as compression fracture of T12,

C5-C6 disc herniation (actually listed as L5-6), right temporal laceration, right fractured femur status post ORIF on 2/5/12.
Dr. saw the worker for initial consultation on 04/03/2012. The worker complained of "significant mid back pain and some neck pain and upper extremity radiculopathy and paresthesias". Neck pain was rated at 1/10 and arm pain was rated it 5/10. Current medications included Aleve. On examination there was right upper extremity weakness with strength grade 4/5 for the wrist extensors, biceps and triceps. Deltoid strength was 4-/5. The right triceps reflex was decreased compared with the left (1+ versus 2+). There was no tenderness over the cervical spinous processes. There was full range of motion of the cervical spine. On the scanned document the text was obliterated pertaining to Dr.'s discussion of the MRI of the cervical spine. The second page of the document mentions cervical stenosis. Dr. recommended CT myelogram of the thoracic spine and CT myelogram of the cervical spine. He noted that the MRI did show some amount of stenosis; however the quality of the MRI film was poor. He advised the worker to continue to wear his brace at all times. On a separate document Dr. discussed x-rays of the cervical and thoracic spine, noting that cervical films showed no evidence of fractures, spondylolisthesis or soft tissue abnormalities. Thoracic films showed anterior wedge compression of the T12 vertebral body.

On the outpatient follow-up visit on 05/30/2012 Dr. reviewed records from the CT myelogram of the cervical and thoracic spine. There was diminished filling of the right C6 nerve root sleeve with normal filling on the CT scan. He noted that most of the symptoms were on the right, with,"decreased filling of the nerve root". He recommended a right-sided C5-C6 selective nerve root block, stating that it would be both therapeutic and diagnostic. A selective nerve root block at the right C5-C6 level was requested 5/30/2012, with diagnosis codes 805.2 and 723.0.

Dr. saw the worker for an outpatient follow-up visit on June 5, 2012. The worker's orthopedic surgeon had prescribed a bone stimulator to aid healing of the femur fracture. Dr. noted that a recent EMG indicated left C6-C7 radiculopathy with possibly left median nerve compromise. Physical examination was reported to show "bilateral radicular symptoms left greater than right at C6-7 radiculopathy". Reflexes were 2/2 and equal. The right shoulder was tender with palpable enlargement of the AC joint. Shoulder range of motion was normal but painful with full flexion and abduction. There was a visible defect in the right deltoid insertion or the muscle was partially transected. The working diagnoses were the following:

- Cervical disc injury C5-C6 with possible bilateral C6-C7 radiculopathy. EMGs confirm left C6-C7 radiculopathy.
- Compression fracture at T12.
- Right comminuted midshaft femur fracture, status post intramedullary pinning.
- Multiple lacerations of face, right upper arm, and right knee, status post repair.
- Partial transection of the distal deltoid insertion of the right upper extremity.
- Ruled out internal derangement of the right shoulder and right knee.
- Situational depression.
-

Dr. recommended remaining off work. He requested MRI of the right shoulder, physical therapy, continuation of Cymbalta 50 milligrams daily, follow-up with the orthopedic surgeon

and with Dr., and reevaluation in one month. A DWC Form-73 was submitted with the recommendation not to return to work between the dates of 6/05/2012 and 7/03/2012. Dr. submitted a request for MRI of the right shoulder and of the right knee.

DIAGNOSTIC STUDIES

- 02/04/2012 CTA of chest, abdomen, pelvis.
    - Normal CT angiography of the neck, chest, abdomen and pelvis.
    - Mild wedge-type compression fracture of T12. The radiologist reported that there does appear to be small lateral accessory spinous processes with the tip of the process on the left fractured at T12. No other abnormalities noted throughout the thoracic and lumbar spine.
- 02/04/2012: X-Rays of the Right Femur:
    - Severely comminuted midshaft fracture of the right femur width posterior displacement of the distal femur and approximately 4.5 centimeters overriding of the fracture fragments.
- 02/04/2012: X-Rays of the Left Hand: negative radiographs.
- 02/04/2012: X-Rays of the Right Hand: negative radiographs.
- 02/04/2012: X-Rays of the right shoulder: negative radiographs.
- 02/04/2012: AP X-Ray of the Pelvis: no radiographic evidence of fracture dislocation.
  02/04/2012: X-Rays of the left knee: negative radiographs.
- 02/04/2012: PA X-Rays of the Chest:
    - Small round nodule overlying the right posterior fifth rib which may be intraparenchymal. Otherwise negative radiographs of the chest.
    - 02/05/2012: MRI of the cervical spine without contrast, two copies of the report.
    - There does appear to be a disc bulge centrally at C5-C6. The disk compresses the ventral aspect of the thecal sac narrowing the AP diameter approximately 8 millimeters. The disc is also in close proximity to the exiting right nerve root although there is no clear encroachment of the nerve root.
    - The remainder of the cervical spine is unremarkable for spinal stenosis or nerve root encroachment.
    - This exam is technically less than optimal due to artifact.
- 02/05/2012: intraoperative views of the right femur for location of an intramedullary rod.
- 02/05/2012: Four views of the right femur:
    - Since the previous examination there has been placement of an intramedullary nail in retrograde fashion through the femur traversing the previously demonstrated comminuted midshaft fracture. Femur is now in anatomical alignment. The femoral head remains located.
    - Alignment of the knee is unremarkable.
    - 02/05/2012: portable image intensifier was utilized in surgery. Actual fluoro time: 1.50 minutes.
- 05/02/2012: CT of the cervical spine without contrast:
    - Mild congenital narrowing of the spinal canal from C3-C5. Narrowest AP diameter at C5-C6 measuring nine millimeters with minimal flattening of the spinal cord.

    - Small disc osteophyte complex 1-2 millimeters in size at C4-C5, C5-C6, and C6-C7. No focal disc extrusion.
    - Mild to moderate foraminal stenosis at multiple levels. No severe stenosis or nerve root compression.
- 05/02/2012: Cervical Myelogram:
    - Diminished filling of the right C6 nerve root sleeve, normal filling on the patient's CT scan without significant right foraminal stenosis is present at the C-5-C6 level.
    - Evaluation of the thoracic spine shows mild to moderate superior endplate compression fracture of T12.
- 05/02/2012: CT of the thoracic spine without contrast (two copies).
    - Normal thoracic discs. No cord compression.
    - Normal intervertebral foramina.
    - Subacute to chronic superior endplate compression fracture of T12 is noted with 33% loss of height in the anterior aspect of the vertebral body. No significant narrowing of the spinal canal and no cord compression.
- 02/07/2012: Via Christi Recent Results-All Documents, including laboratory test results.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

As noted above, Coventry Workers' Comp Services referred the injured worker to Dr. for care, evaluation and treatment of the spinal injuries, which were specifically listed as compression fracture of T12, C5-C6 disc herniation (actually listed as L5-6), right temporal laceration, right fractured femur status post ORIF on 2/5/12. Dr. records document subjective and objective evidence of cervical radiculopathy. He recommended imaging studies. Cervical myelography disclosed underfilling of the right C6 nerve root, which Dr. interpreted to be consistent with findings on the history and physical examination. He recommended selective right C5-C6 selective nerve root block based upon the clinical findings as well as the findings on the imaging studies.

Dr. findings were suggestive but not diagnostic of right cervical radiculitis/radiculopathy. On June 5, 2012 Dr. noted that the pain involved the left upper extremity more than the right. EMG findings were not available for this review, but Dr. noted that EMG findings were abnormal in both upper extremities.

According to the ODG Integrated Treatment/Disability Duration Guidelines, Neck and Upper Back (Acute & Chronic), (updated 01/30/12) pertaining to Epidural steroid injection (ESI) the proposed selective nerve root block is justifiable for diagnostic purposes, but not necessarily for therapeutic intervention. Based upon the information made available for this review, the first three criteria of the four listed criteria have been met; therefore, the requested treatment is medically necessary.

Criteria for the use of Epidural steroid injections, diagnostic: To determine the level of radicular pain, in cases where diagnostic imaging is ambiguous, including the examples below:

(1) To help to evaluate a pain generator when physical signs and symptoms differ from that found on imaging studies;

(2) To help to determine pain generators when there is evidence of multi-level nerve root compression;
(3) To help to determine pain generators when clinical findings are suggestive of radiculopathy (e.g. dermatomal distribution), and imaging studies have suggestive cause for symptoms but are inconclusive;
(4) To help to identify the origin of pain in patients who have had previous spinal surgery.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- ☐ **AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- ☐ **DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- ☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- ☐ **INTERQUAL CRITERIA**
- ☒ **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- ☐ **TEXAS TACADA GUIDELINES**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**